



## SGLS Opening Comments

By RADM Bruce Gillingham



### SG AND FORCE VISIT GITMO

SG and FORCE with U.S. Navy Medicine Readiness and Training Command Guantanamo Bay (U.S. NMRTC GB) leadership and hospital staff on May 11, 2022.

Photo by Ms. Dawn Grimes

**F**amously, John Paul Jones said back in 1778, “I wish to have no connection with any ship that does not sail fast or intend to go in harm’s way. It seems to be a law of nature—inflexible and inexorable—that those who will not risk cannot win.” We know that the landscape has changed, that we’re facing challenges from China and Russia, and we’re going to have to be very focused about how we defend our allies and our country’s national interest. And you know—all of us know—that the way that we’ve operated for the last 20 years in the desert, in Iraq, and in the mountains of Afghanistan, is not how we’re going to be deployed in the future. So now is the time for us to focus on getting our folks ready and ensuring that we’re properly organized, trained, and equipped to execute our mission. This is a leadership symposium and as leaders we have to ask ourselves, what am I doing to make sure that the sailors and civilians that I’m in charge of are prepared to do their wartime missions? And I hope that you truly reflect on that and provide that introspection because—and as we go through these discussions, certainly as I make decisions at my level, those are the key considerations that I keep in mind. . .

NOTE: The Surgeon’s General Leadership Symposium (SGLS) was held from May 16-18, 2022 at the Defense Health Headquarters, Falls Church, VA. Comments and select panel discussions that appear in this edition The Legacy have been adapted for publication.



# NAVY MEDICAL LEGACY

## A RETIREE DIGEST



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### EDITOR'S NOTE:

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We are responsible for the operational readiness of today's Naval forces and we're responsible for our own medical forces to be ready. We have no higher priority than protecting the health of those entrusted to our care, and Navy Medicine's priorities are direct, clear, and relevant. We provide well-trained people, working as expeditionary medical experts on optimized platforms, operating as cohesive teams, demonstrating high reliability of performance to project medical power in support of Naval superiority. That is what uniquely sets us apart and why we wear the uniform. And I'd like you to share that narrative in your units and with your folks as you go back because central to being able to project that medical power as leaders, we have to be inclusive and thoughtful; we need to hold ourselves accountable. We're going to talk a little bit about get-real/get-better, but we fundamentally have to embrace the responsibility that we're in a significant period of change and we're all responsible for making sure that we're appropriately ready for the next conflict. Next slide please.

### **GET REAL, GET BETTER**

I think everybody's aware that this is a Chief of Naval Operation's "Get Real, Get Better" initiative. We've sent information out; we've discussed this in a senior leader forum, but it really blends beautifully with the third "P" – Performance. We have the courage to understand where we're falling short. We embrace the responsibility to address that. We do everything at our own levels to try to resolve any issues and then we elevate issues where we need barrier removal or assistance. I'll tell you, VCNO emphasizes that the answer is generally not more resources, more money, more people. It's often process. So are we going about things the best way? And this is an opportunity for deference to expertise. There are people that you work with that have solutions that we need to surface and widely share. But truly we have to have the courage to recognize where we're falling short, and as Thomas Jefferson said, "Honesty is the first chapter in the book of wisdom." And so are we truly facing the brutal facts?

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***"I think any great organization understands how important supporting and developing its people are."***

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I love the story about Vice Admiral James Stockdale, one of our great Naval heroes, after he was shot down and drifting down into Hanoi with his parachute. He recognized that his life had dramatically changed, and that each day was going to be extremely difficult as the captive. But, he also held the longer-term belief that no matter what, he would prevail, that he would return home with honor, and so that's the capacity to embrace the brutal facts in front of you but still have that faith that we can and will get better and we will meet our very important mission.

### **DIVERSITY**

Certainly everybody understands how important diversity and inclusion is to our success. That's not just ethnic or gender, that's diversity of thought and background, and that we understand everyone that we work with, that we understand their background and the unique skills that they bring to the fight, and I'm really looking forward to Captain Toni McRae's discussion on diversity and inclusion later in the meeting. We're doing a number of things to foster discussions of diversity. I'd ask you to continue on an informal basis the enduring conversations that we started following the racial tension in Minneapolis, and use those opportunities to really understand individual's backgrounds and perspectives. We're doing this more formally with what's known as our "Dive-in" series. We did the first of these with Ensign Alexis Russell, who is a first-year medical student at USUHS. She's the first African-American woman who was selected for the Enlisted to Medical Degree Program (EMDP2), and she's a remarkable young lady who left a very dysfunctional home life, joined the Navy, and through tremendous persistence and drive has now become a medical student. And despite the challenges of a first-year medical student, she continues to mentor others who are following in her footsteps. Fundamentally, there's solid evidence that organizations that embrace a culture of excellence make better decisions and are more effective overall, and diversity and inclusion and equity are important pillars of that culture of excellence.

### **PEOPLE**

So, of course, the first "P" is People. I think any great organization understands how important supporting and developing its people are. Each of our Corps—Civilian,

Corpsman, Dental, Medical Service, Nurse, and Medical are critical to our readiness mission, and we will have a discussion about that and where we sit with divestiture—that's clearly a key issue—but for now, just know that there will be no divestitures in FY23. We continue to work in a multidisciplinary way to truly define what the medical manpower requirement is.

One of the key things you should know is that we continue to work with the Defense Health Agency, and we'll be transferring more than 8,600 Department of Navy civilians employed at our MTFs to the Department of Defense to work under the Defense Health Agency (DHA), and the team has done tremendous work to make this happen. Obviously we want to support all of our civilians as they make this transition. When the dust settles, we'll still have more than about 3,000 Civil Service employees supporting our headquarters, our Navy Medical Readiness and Training Commands (NMRTCs) and years within PREVMED and Public Health, so our civilians, despite that large transfer, will remain a huge part of our success going forward. Force will be able to share with you some great initiatives with regard to our Hospital Corps. Just recently we made the decision that we're going to train our A-schoolers to become EMTs and that they will take the EMT examination at the end of A School. And so this is, I think, a huge step forward, occasioned, frankly, by the fact that when we deployed in Defense in Support of Civil Authorities (DSCA), many of our corpsmen weren't able to participate as the civilian hospitals didn't recognize the role of corpsmen since they had no formal certification. So, this is a big step. And I think as we pivot to operational readiness, enhancing that, that EMT will be extremely beneficial. We're doing continued trauma training, and I'm excited that we started a new partnership with the University of Pennsylvania, and we have 11 nurses, doctors, and corpsmen embedded at the University of Pennsylvania in their trauma center and are refining the model by which we will use that platform and others to prepare our teams for deployment.

## PLATFORMS

Obviously, we deploy on platforms, and that's what makes this unique. Obviously, or arguably, our key platforms are our hospital ships, and of course, *Mercy* is underway with Pacific Partnership '22, but it's important to not

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***"We want to demonstrate high-reliability performance, and I would argue that our response during COVID has done that."***

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lose sight of the fact that our MTFs, as organized via the NMRTCs, remain critical training platforms for us. We've got some exciting developments you see down there at the EPF. T-EPF-14 will be the first formal Flight II variant. This is an exciting new capability because that will allow us to do Role-2 afloat damage control surgery and medical care. It will allow us to respond directly to a ship casualty, for example. It will hold about 100-person medical team. We'll have two ORs. And it will land an Osprey. So, this is a huge step forward. Force and I helped christen T-EPF-13, which is a prototype of the USNS *Apalachicola* last October, and then T-EPF-14 future-USNS *Cody* will be the first EPF Flight II. Our Marine leadership is going to be telling you about how they're adapting to force design and how we're adapting medical capabilities, particularly in some small surgical teams, as well as really leading the way with Role-1 whole blood transfusion, so really, some exciting things happening with regard to our platforms, which is really—our ability to function on those in an expeditionary environment is critically important, and I will tell you that remains our highest priority is getting those expeditionary platforms right, and you're going to hear more about that.

## PERFORMANCE

We want to demonstrate high-reliability performance, and I would argue that our response during COVID has done that. When you look at the guidance that we've provided to the fleet, now in its sixth revision, was based on rapid cycle feedback, best available scientific evidence, and then adjusting that to the requirements and the unique setting of the fleet, taking feedback from them and then adjusting once vaccines were available. So, we have and will continue to develop high-reliability behavior. We will continue to manage the unexpected, which is, essentially, the essence of high-reliability. We won't be perfect, but we're going to continue to always seek out sources of potential



failure at the lowest amplitude; we're going to address those; we're going to use get-real/get-better behaviors to do that. We're going to continue to communicate, anticipate, identify, resolve, and share to solve problems that threaten war fighter readiness and survivability. We're going to do that across the One Navy Medicine continuum, and I'm excited with some of the things that we've seen with the fleet health integration panel, for example, adopting the patient safety and quality line of effort, and really leveraging all that we've learned in the MTF to raise the bar for the care that we provide in the fleet, and certainly in the Marine Corps, following suit in that regard.

Obviously, one of the issues that remains very challenging is mental health care. I'm excited to say how much we responded to those challenges. We have a lot of work to do, but you're going to hear much more detail about those initiatives. The one that I'm particularly excited about is called Orion. Everybody is familiar with our ability to respond with Sprint Teams to units that had a tragedy. We recognized after *Fitzgerald* and *McCain* that the initial response was great, but what about those who were at psychological risk? How did we make sure that they got follow-up? And so Orion actually does a caring contact to those that are identified by the Sprint Team as being at-risk. And following the *McCain* and *Fitzgerald*, about 20% of those that were contacted said, "Yes, I actually could use some additional help," and were provided appointments within our behavioral healthcare system.

As I speak to you, about 36% of our mental health professionals are embedded within the fleet, a number of different units, and about 30% of our behavioral health techs. And so clearly a work in progress, but I'm so proud of the team for leaning forward and really getting after—not only responding to the crisis, but thinking about ways to build resiliency and toughness. Just, for example, with the USS *George Washington* and its cluster of suicides, a sprint team responded right away. We've added some additional mental health capabilities there. Admiral [Darin] Via and his team have done a phenomenal job to lean forward and provide support to make sure that anybody who needed care had first-in-line privileges for those referrals, and then follow-on with Orion to get you to track that crew and make sure those at risk are getting the care that they need.

We've done some remarkable things in terms of wom-

en's health, and you're going to hear more about that, but full-scale contraception, walk-in clinics at the fleet, our embedded women's health provider program on the pier that is very successful, and we're looking to expand. And so I salute all of that work.

## POWER

Power is where the rubber meets the road. So, if you take those first three "Ps"—great people capable of operating downrange, exercising their expertise, put them on optimized platforms and they demonstrate high performance teamwork, you get medical power. And I'll confess that when I wrote that three years ago, I was thinking about combat casualty care, but COVID has shown us the range of ways that we project medical power, and certainly our public health, PREVMED, infectious disease, our critical care teams, our respiratory technicians—all of those who have played a leading role in the COVID response deserve tremendous appreciation and praise.

We also sent out teams, of course, throughout Operation Allies Refuge and Operation Allies Welcome here stateside. There's no playbook for those. Force and I visited the state-side teams, and it was remarkable how they adapted and made things work. Truly hosted and welcomed our allies from Afghanistan. We've had some additional public health challenges with the Red Hill fuel contamination in Hawaii. Captain Michael McGinnis and his team rapidly established a joint health services working group and that was not only joint, but it was interagency to include the Department of Health from Hawaii, the CDC, the agency for toxic substance and disease registry, as well as other agencies. They rapidly—I set up an incident report endorse the Defense Occupational Environmental Health Readiness System so that we can track those upwards of about 10,000 individuals and potentially identify any long-term health effects. So clearly, Navy Medicine has been flexing its muscle and been doing a phenomenal job well beyond our traditional capabilities set, and so really appreciate that. We can't lose sight of our R&D folks and the great work that they've been doing. They've been incredibly important partners in the scientific panel that we set up early on to deal with the very dynamic situation with COVID and contribute to our now-biweekly—it was weekly—scientific report that gave our leadership the latest evidence on COVID and its re-

sponse. Clearly the CHARM study that was done at Parris Island was really a national level—provided national level information about young congregate populations and their exposure to COVID—that plus an article written about the findings on the Roosevelt that were published in the *New England Journal*, so truly some terrific work that's being done.

These have been extremely challenging, unprecedented times, and Navy Medicine has risen to the occasion. But now, we can't rest on those laurels because we recognize, as I said, the landscape has changed, and our center of gravity has to be our commitment to providing expeditionary

or maritime medical care for our forward deployed Naval and joint forces. And I'll emphasize the Naval because even more than in the past, our integration within the Marine Corps as it revolutionizes its approach through force design, which you're going to hear about. It's critical that we get that right and that we're integrated in that process. But, our One Navy Medicine team has been impressive. We will continue to be impressive. And I thank you for your leadership during these incredibly challenging times. ●



## FORCM Opening Comments

By FORCM Michael Roberts



**G**ood morning SG, DSG, Admirals, commanding officers, executive officer, master chiefs, leadership team. Thank you all for taking the time to come out here and come do this. And I'd also thank the many people who put this together behind the scenes.

Over the next few days we're going to discuss several topics regarding the future of Navy Medicine. There will be several panels led by stakeholders and project managers and have made available for questions regarding various issues pertaining to our current and future state. But after the next three days and all topics covered, I assure you

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the biggest takeaway will be Navy Medicine has changed. In tandem with DHA, we'll ensure sustained operations within our MTFs, but our primary focus is ensuring that we're prepared for operational needs of tomorrow. Earlier this year, the CNO released his change of command where he brought forth the concept of "Get Real, Get Better." His call-to-action charges us to self-assess and self-correct. His charge to us is to be a "learn-it-all" versus "know-it-all," and this charge is one of the ways that we will succeed in shaping the future of Navy Medicine. When we identify areas of improvement and work towards fixing the root of

the problems, we're "embracing the red." This is not an unfamiliar concept. This aligns with the pillars of high-reliability organizations within an HRO. One of the pillars—continuous process improvements—is as necessary to medicine as leadership. And a process will again be critical as we move forward in Navy Medicine with operationally-focused scope. The state of Navy Medicine today is a state of change. Forward-thinking leaders are conceptualizing the usage of medical assets and preparation for possible war that lacks air superiority and battle space that spans vast distances. This is very different from the battlefields of the past three decades. This presents problems that Navy Medicine has not had to overcome in recent history, but the

hurdles are not insurmountable. We have the best sailors to overcome any challenge. By emphasizing the four Ps and embracing the red, Navy Medicine will continue to produce talented, multi-faceted medical professionals capable of mission success regardless of the challenges created by our adversaries, distance, or technology. This is our direction; this is our change.

Again, thank you for all coming. I really appreciate it. I'm looking forward to two things—I'm looking forward for the briefers to brief a great topic, and then I'm also looking for the collaboration and discussion that comes out from the brief. Thank you. •

## Secretary of the Navy Remarks

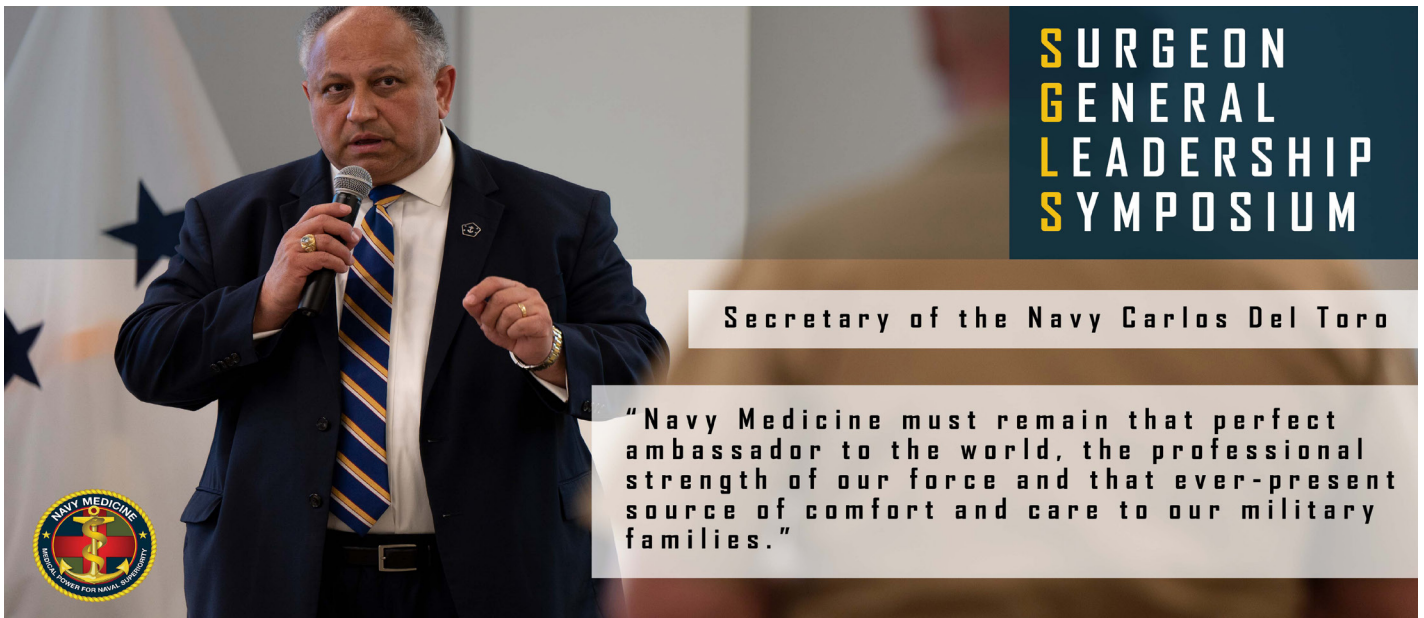
By Carlos Del Toro



**I**t's great to be here and I hope I can make my way through it, but I got to tell you one of the things that I've enjoyed most out of the short nine months that I've been Secretary of the Navy has been actually interacting with your Surgeon General. He is, through and through, a true leader who cares deeply about all our sailors and Marines, and he cares deeply about all of you in this profession. It's such an honorable profession, and I feel really privileged and proud to be serving by his side. So, with that said, thank you, Admiral Gillingham, wherever you may be. And let me thank each and every one of you here today and those that are brass tuning in from around the world. From every ship, to the most remote forward position, you are there fulfilling both your Hippocratic Oath and your oath of office. And I want to thank all your families as well, too. This is—all of you know, as senior leaders in our Navy and our Marine Corps—the role that your families have played and the success of your own personal careers is also nothing short of extraordinary and it's really important to thank them. In fact, I started off my day—see, I'm already deviating from the speech I wrote—but I started my day off today—it was a really great start to a day—by officiating of the commissioning ceremony, what they refer to as the battalion of midshipmen, which make up the midshipmen from the George Washington University, Catholic University, Howard University, and Georgetown University.

And I did take an extra moment and asked all those family members to get up and thanked them for the development of those great midshipmen and for them sharing this great Navy-Marine Corps experience that we all know very well. So, the National Defense Strategy does place a premium on campaigning forward in order to be sure our adversaries and response in force where we're needed. That means that we do need a distributed and expeditionary medical support to ensure the readiness of our sailors and Marines and our families. Your extraordinary response to the COVID-19 pandemic over these past three years has contributed to that greatness in countless ways. The mitigation efforts to caring for those with the virus, the historic lift that resulted in the vaccination of our fleet, you have answered the call. You have set the standard of the entire joint force, ensuring our continued fleet operations while also directly responding to the medical needs of the American people—24 American states. Corpsmen along with green infantry, doctors and nurses aboard the *Comfort* and *Mercy*—you are integral to every aspect of our mission. I want to make sure that you all understand full-scope what we must do as a department to meet our responsibilities to the joint force and to each airman every day. Every element part of the Navy must be aligned to support these three guiding principles. First: maintain and strengthen our maritime dominance and expeditionary capability. Second: empower our Marines and





sailors through a culture of war fighting excellence found in the strong leadership and treating each other with dignity and respect, and third: strengthen our partnerships across the joint force with industry and our international partners around the globe. This is our Department of the Navy strategy and you play a very important role—it’s clear, it’s concise and it’s transparent. And under Admiral Gillingham’s leadership, you’re contributing effectively to each of these three priorities. You strengthen our maritime dominance by ensuring the readiness of every shipping unit, deploying forward alongside our sailors and our Marines, often to harm’s way. You strengthened our partnerships around the world. One of the greatest symbols of hope on Earth is that Red Cross and the white background arriving at a crisis.

And most importantly, you help empower our people and their families. People are the foundation of everything we do, and people are the basis of your profession. Caring for their physical healthcare needs is vital to the readiness of our force, and the fulfillment to our obligations to those who serve, and caring for their mental health is equally important. May is Mental Health Awareness Month, and I know that this is a year-round priority for you, and it must be so for our entire department, and I assure you that it has been for me from the very first day that I became Secretary of the Navy. The moral of this is *George Washington*, which unfortunately has been the site of several recent suicides, as you know. Every suicide is a tragedy with repercussions that extend to the family, shipmates, and loved ones for years to come. We must do more, not

only for our sailors and our Marines in crisis, but for the everyday health and well-being of all of our people. And every gathering of Navy and Marine Corps leaders from the deck plate to the E-ring, I’ve emphasized the importance of breaking the silence and the stigmas.

This morning I spoke about it again at the NROTC Commissioning that I spoke about. Getting that in the door is only half the battle. We must be ready with the capacity and the ability to also listen and respond and treat our people when and where they are needed. That means investing in embedded mental health units out in the fleet, including psychiatrists, psychologists, social workers, and nurse practitioners. It means funding the right training to handle the many issues that can impact the sailor and Marine’s well-being and getting ahead of substance abuse, domestic violence, and post-traumatic stress. Many of you know that all of these issues are very much interrelated. It means working closely with our Chaplain Corps as well and other leaders who can provide the right guidance and spiritual care for a sailor or a Marine in need. It means making sure that we follow up on our referrals and our communications across the services and with the DA and civilian partners so no one falls through the cracks. There can’t be no wrong door any time a sailor or Marine has the courage to ask for help, we’ve got to respond. And it also means taking the time to do so, and I know all of you in this room get it. When I’m out there talking to our front line warriors on the ships—commanding officers, chief petty officers, whoever they might be—I tell them, “You’ve got to take the time



and stop. The mission is important. I get it. But in times of peace, life is more important than mission.” We have to take the time to emphasize that a person is in need and look out after our fellow shipmates. Of course, I’m not telling you anything you don’t already know. What I want you to know is that this is a critical priority for me. And I want you to let me know where you are running into problems getting our people the care that they need. We’re going to talk about this in the Q&A, I’m sure. Let’s keep the lines for communications open with me, with each other, with the Surgeon General after you leave this symposium.

Our people are our strength and I intend to take full advantage of this collective expertise, ingenuity in every which way, which is why I’m here today. In the end, all leadership comes down to is trust. Trust that you put the Navy and Marine Corps team in the Nation first and make this better every single day. I know you do. Our people trust you. They care. Take care of them—and so do their families. We must all prove ourselves equal to that trust. Navy Medicine must remain that perfect ambassador to the world, our professional strength of our force, an ever-present source of comfort and care to our military families. Thank you for the leadership that you provide in your service. I appreciate the hard work you put in day in and day out over the course of your career at sea and at shore. And certainly that leadership from enterprise needs is right here in this room and that together we will provide the world’s finest sailors and Marines. So, I thank you.

I apologize for getting a little bit emotional at the start of this, but I, and my family, has been a beneficiary of all your care throughout my career in active duty and also as a retired vet. And it’s the reason why I paid the call to come back to service to our nation, so that I could bring all the lessons that I’ve learned both in the Navy and the private sector for our mutual benefit working together to try to resolve some of these very, very tough problems that often are very difficult to resolve, as you all know. ●

## Q & A with the SECNAV

**Q: I think there’s opportunities for our behavioral health techs to get advanced education in counseling. Is there anything under consideration, or do you see an opportunity where, just like our substance abuse counselors, the aperture is opened wider and we expand that ability to support all sailors at all levels?**

A: I think the solution has to be growing all around. We need to grow more of our own mental health professionals at all levels—psychiatrists, psychologists, the technicians. I don’t think there’s any shortage of people in this country who want to be hospital corpsmen. We need to bring greater percentages of them into the mental health field and train them appropriately to try to fix the problem. And that’s not a short-term fix. That’s a medium to long-term fix because it takes years to build that cadre and the right numbers to get there. But, if we don’t do that, I just don’t know how we’re going to get there because trying to compete with the private sector is not going to be the solution, at least no time in the near future.

**Q: Although adequate mental health providers is certainly a valid focus is the Navy looking into the "why" behind the increased need for mental health care to include increased stressors on work/life balance, operational tempo and demanding resources to address the need for mental health?**

A: Great question. How many of you joined the Navy in the 1980s? Is our Navy today different from the Navy back then? In a good way. In many ways it is a lot different. When I joined in 1979, I think about what the Hearing Conservation Program was like, where you walk out of this space and that’s your Hearing Conservation Program. The Heat Conservation Program involved sticking your head in the vent in the engineering space for 15 minutes at a time, and then when there was a steam leak in the engine room, your chief sent you out there with a broom, and if the broom went up on fire you knew you had a steam leak. And then you tore up the lagging that had asbestos in it and asbestos flew everywhere. That’s no longer the Navy we work and live in. Now are today’s problems challenging? Absolutely. In so many different ways. But perhaps some of the problems that we actually surface and bring to the surface we talk about, we try to fix them, and that’s a good thing that we’re actually communicating about it. It’s a good thing that we’re caring about our people. And unfortunately, we discover challenges everyday that have been

neglected, and it's our responsibility as leaders to address those challenges as well, too. This whole issue about the stress in the shipyard, it's always been stressful to work in a shipyard.

I built the USS *Buckley*, a brand new warship in Pascagoula, Mississippi, and I lived in the shipyard for a year and a half as a bachelor. But, I recognized that that was a stressful environment that we were going into, and I had to go—not just me, my entire crew and my ward room, my chief's mess—we had to go above and beyond the call of duty to explore all the creative ideas that we could to make things better for our crew because again, that's what leadership's all about. I did a shift in home port on a cruiser from San Diego to Yokosuka, Japan, you want to talk stress?

That's a stressful environment as well. I myself showed up to San Diego. Three weeks later I came home and told, "Honey, I've got good news and bad news for you." I said, "The good news is you're staying in San Diego with the children. The bad news is I'm going out to Japan for the next nine months and I'm leaving you behind by yourself with four kids, including one under the age of one." Was that stress on my wife who suffered from lupus at the time? Hell yeah, that was stress. So, I'm not going to make excuses. We're going to find ourselves in these situations that are stressful. The difference is what are you going to do about it to make it better? So again, we have to—my captain and myself and the crew—alright, what are we going to do to make the crew's life better? Let's built up the ombudsman channel; let's communicate constantly with the families; let's find out where all the stressors are and how can we solve people's—you have to take the time to remove yourself temporarily as a pure war fighter and go take care of people's problems so that they can be good war fighters later on without the stress or the burdens that they have to face. And that's what real leadership demands and that's what we need in our Navy.

**Q: My concern has to do with the politicization of health-care services, the threat to sound services that may have been available, may not be available in the future, and the considerations that women may be making in terms of serving in military forces. Female force readiness is readiness, and so how much do you think that pending decisions for the Supreme Court may have an effect on recruitment and retention of females based on geography and the availability of women's health services writ large. These are things that I certainly see on social media forums and different areas of debate, and I'm not asking it, certainly, as a political ques-**

**tion, don't really have an interest in that, but it's a practical question in terms of women's decision making and career opportunities and some of the variables that women think about who are expecting to be deployed around the globe.**

A: You know what the definition of politics is? Anybody, this is not a joke. Look it up, politics is the "art of the possible." I view politics on how can we use these interactions—this is the greatest country on the face of the earth, it really is, and I was born in Cuba and I'm going to get to your answer real quickly. But, it's the greatest country on the face of the earth because you can accomplish anything that you want, and you can get anything you want done, right? But, we all have to be participants in this great American democracy, and it's ugly and it's dirty and it's just that some checks and balances is sometimes there for a reason, but unfortunately, sometimes the politics goes to the extremes and that's where it gets really ugly, right? And it often interferes with common sense as well.

So, there were a lot of questions that you asked in your opening statement with regards to diversity. First and foremost, it really is an issue of combat readiness. We're an all-volunteer force. Compare what we do to what Russia does with their inscripted force, right? We're an all-volunteer force. People join the Armed Services because they want to serve their country; they want to do good and they want to make the world a better place, right? So that's very, very important to the equation to start with. But, the only way that an all-volunteer force succeeds is by being able to recruit from the entire marketplace, the entire marketplace. And you know what? About 50% of our marketplace happens to be female. I don't get emotional about this. This is the business side of me coming out now. About 50% of my company was female. You've got to recruit from every part of the marketplace, and in a world where women are making such great contributions in every segment of society in every profession, why wouldn't we recruit more aggressively to get more women to come into the service? I talk about it all the time. And we've made good progress since the days when women first graduated from the academies.

For example, in 1980, I was so proud that my first week as Secretary of the Navy, I sat down, I wanted to talk to my legislative affairs directors about our Capitol Hill's tragedy, and in walked a one-star general and a two-star admiral—both of them females—and I paused for a second and I said, "I got to tell you, as someone who served with some of the first women at the Naval Academy and saw the troubles that they went through and

the challenges that they faced, I'm so proud to be here today with both of you. And we're going to work to make this Navy a better Navy." And I'm so proud that I had a role to play in nominating Lisa Franchetti to be the second female to serve as Vice CNO, and I pray that she gets confirmed by the Senate.

So, it's about combat readiness is what it's about. As far as discrimination, I try not to politicize any of that stuff. You shouldn't discriminate against anybody, at all, or use destructive behaviors against anybody at all. We're professionals; that's why we joined the Navy. Anybody who takes the oath of office just like those 29 midshipmen this morning and are willing to just literally sacrifice their lives to serve their country deserves to be treated with dignity and respect, regardless of if they're men, women, whatever they might be. And that's why none of you should tolerate it because the first time you turn your head on a nasty joke or something—however funny somebody might think it might be—you've now set the new standard.

I went to an event where there was an enormous amount of retired Marines—an enormous amount of retired Marines—and just three weeks before, or something like that, I discovered the story of this young female Marine who had come into a squadron, and in the typical, traditional manner, was given a call sign that is completely inappropriate. And I told that story at that gathering of retired Marines, "Hey, folks, times are changing. Either get with the program or move aside so that others can make our Department of the Navy a far better place to work," and so forth. So I have no tolerance. I don't have to convince everybody either that my way is the right way, I really don't. It is the right way. It's your way; it's our way. And if you don't want to get on with the program, then step aside and go to something else. So, I hope that answers some of your questions. I'm sure there were more embedded questions there, but— Yes, sir?

**Q: With regard to distributed maritime operations, force design for the Marine Corps, and expeditionary advanced base in operations, we're seeing some significant changes in organization in request for structure and request for how the design of the force is employed. How do you see the future for Navy Medicine to support the operational force?**

A: Change is always hard, let me start off there. And change is good. But, it's only good if it's balanced correctly, right? To protect all the equities that are involved, and I hope not to give just a political answer here. You know, I saw the evolution of DHA from its very beginnings, and as a business person who served

in the private sector for 17 years and started my own company, I can argue that there were a lot of efficiencies that were put in place because of the establishment of DHA, across the entire enterprise. It's a massive enterprise, as you know, with tremendous costs associated with it. And I think that there have been a lot of really great things that have come about because of DHA and the policies that went along with it.

At the same time, I don't think that culturally we could ever neglect the fact that each of the services have their own traditions, their own cultures, their own mission sets that do vary, and I think that that has to be respected because the consequences are high, and they're highest in times of conflict. So, when a Navy corpsman goes to battle with a Navy squadron, or a platoon, or a battalion, they've been trained for that very specific mission. Or, Navy surgeons on aircraft carriers taking care of pilots—those are very unique mission sets. And we've got to make sure and do everything we can to protect that component of our Navy Medical Corps in order for it to be effective. And I'm also not naïve to understand that organizations can sometimes become too large and lose sight of the reasons why they were brought to be in the first place. We can't just allow that to happen. There has to be oversight over that as well, too. So, I know I'm giving a very complicated answer to a very difficult question, but there has to be strong advocates for the military medical components of the work that you do. And I think that those of us who certainly have served in uniform or gone to war understand that clearly, and it's our responsibility to articulate that to the leadership in the building so that we find that right balance between the two. And perhaps, yes, there were efficiencies in terms of bringing civilian providers to hospitals where there is large representations of retired folks like myself, for example. But, there's also value in bringing combat medical professionals into hospitals where, perhaps, there's a lot of trauma work that takes place in that hospital to train them, right, in the yard that they're going to be called upon to fulfill when conflict arises, right? And I'm not the expert. You all are the expert in finding that right balance. But, you need to support your civilian leadership as well, too, to understand that and to be advocates for you, and I assure you that I'm a big advocate for you in that regard. ●



# Navy Medicine Foundry Panel



## Looking at the Unique Mission Sets

**RDML Darian Via:** When I originally took a look at the agenda, I recognized there was going to be a lot of discussion. As we look at the agenda, one of the things we recognized was that there might not have been the voice of the ECH 4 and ECH 5 commands, so that's really what this panel is for. We selected a representative group. I've asked the panelists to focus on the force generation, force preservation of the operational forces, which Captain [Therese] Allen and Captain [Elizabeth] Adriano will be speaking. I've asked them to focus on force generation, force development of new accessions and training populations as Captain [Thomas] Nelson and Captain [Raymond] Batz will be talking on. And then I'll be turning it over to Admiral [Cynthia] Kuehner. She's going to be looking at force generation, force development of the Naval Medical Forces Support Command, and both Captain [Anne] Case and Captain [Matthew] Hebert will be responding to her questions.

So, the first question is for Captain Batz and Captain Nelson. For those who have never commanded a unit supporting an accession sight, can briefly describe the unique challenges placed on you—what are your biggest resourcing constraints? How are they working? How are you working internal mitigation strategies to overcome those? And finally, what would be your response to those who would say, "Hey, recruits are young and healthy. Just send us out to the network. Yeah, it's a bag two cost, but it's a lower bag two cost. We're not getting a lot of KSA value. We're taking care of recruits." Send them out in the network, what would the response be? So, I'll turn it over and we'll start with you, Ray [Batz].

**CAPT Batz:** Thank you, Admiral. I currently am the CO for NMRTC Beaufort and NSF Beaufort in Beaufort, South Carolina, in direct support

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**NOTE.** SGLS Foundry Panel has been edited for publication.

## PANELISTS:



**RDML DARIN K. VIA**  
**MODERATOR**  
COMMANDER, NMFL  
PORTSMOUTH, VA



**RDML CYNTHIA KUEHNER**  
**PANELIST**  
COMMANDER, NMFSC  
SAN ANTONIO, TX



**CAPT ELIZABETH ADRIANO**  
**PANELIST**  
CO, NMRTC  
CHERRY POINT, NC



**CAPT THERESE ALLEN**  
**PANELIST**  
CO, NMRTC  
JACKSONVILLE, FL



**CAPT RAYMOND BATZ**  
**PANELIST**  
CO, NMRTC  
BEAUFORT, SC



**CAPT ANNE CASE**  
**PANELIST**  
CO, NMSTC  
SAN ANTONIO, TX



**CAPT MATTHEW HEBERT**  
**PANELIST**  
CO, NMOTC  
PENSACOLA, FL



**CAPT THOMAS NELSON**  
**PANELIST**  
CO, NMRTC  
GREAT LAKES, IL

of the Marine Corps at MCRD Parris Island and Marine Corps Station Beaufort. And the mission of making Marines at Parris Island is, really, I'd say 80-85% of what I do each day. And it took about six months to wrap my mind around everything that goes on in Beaufort, in the low country, but 85% of it comes around making Marines at Parris Island. I'm familiar with overseas and operational requirements. I know a lot of us in this room have had an opportunity to be overseas and operational, but I assumed command 29 May 2020, in a pandemic, and we were still making Marines in Parris Island. It never stopped.

The CHARM study was a "no-fail" mission—using an acronym there. I want to make sure we get—CHARM is the COVID-19 Health Action Response for Marines that preceded CHARM 2.0 and now CHARM 3.0. There are about 15 sessions coming out of the CHARM study, but just suffice it to say, it was clear to me that although overseas and operational commands get the stuff, get the people and the resources first, you've got to consider the accession pipeline because there is no winning the fight tonight without privates, private first-class, and lance corporals in Okinawa. And they come through Parris Island, go to a school of infantry to the tune of 20,000 Marine recruits a year. We get them for about 13 weeks. We have 14 days to go from civilian to fully ready Marine recruit that's becoming a Marine, getting their eagle globe and anchor—week 12—through a process called the crucible, right? We're the foundry, we might as well have the crucible. That's a one-week process, basically, building up for getting the metal that you need to be a Marine. Then there's a finishing, polishing week, we'll say, as we're in the foundry, and then you're off to the School of Infantry.

About more than half of the recruits that the Marine Corps makes each year come out of Parris Island. There's also a Marine Recruit Depot out of San Diego, but there are some key health services and support personnel that I've enjoyed working with them. We have about 50 dentists in Parris Island that drive the train that takes, now, a third- to half- of the recruits have never seen a dentist when they step on the yellow footprint. They go from that mouth to fully dentally ready in 12 weeks with, really, about four days to spend in dental. It's really amazing. It's a unique place to be. I'll be there for about three more weeks. If you want to come down to Beaufort and see what's going on at Parris Island, I'd love to have you, but to talk about—and

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***"We're the foundry, we might as well have the crucible."***

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show you around—but to talk about some of the good things we're doing. We may not have made 20,000 on the button; it may have been 18,500 recruits that are made out of Parris Island. So, we've got to catch up a little bit from a Marine Recruit foundry and getting Marines to the force. So, we're going 21 weeks without a no-show. So in 21 weeks we're going to have new rounds of recruits coming to Parris Island. It started two weeks ago. Some of those weeks we'll have up to 750 Marine recruits standing on the yellow footprints and going through the process, but I just laid out to you a 12 to 13-week process.

To help support this mission, we want the EMF. We want some stacking, want more—about 65 billets and was able to retain 52—the difference is going to be met by the Reservists to the tune of 90. Ninety Reservists are coming, or seven cycles that are overlapping to support this summer. A real testament to working with the DFA, our manpower folks, working with NMFL, M1 and resourcing as well as BUMED Reserve leadership. I really appreciate Admiral [Eric] Peterson [Deputy Commander, Naval Medical Forces Atlantic/Reserve Director of the Nurse Corps] and we have a commander that's directly now assigned to support as an OIC stunt double for NMRTU at Parris Island, and that's our good news story, Admiral.

**RDML Via:** Appreciate it. We'll turn it to Tom [Nelson]. And if you could hit, also, a little bit on are we at risk of losing the understanding of this mission to DHA and how do you function, really, with NTC/RTC to make sure that that mission site isn't lost, or what we need to understand as an organization to make sure even if we aren't executing it from the DON side of the house, it's being executed out of the DHA side of the house. How do we make sure that our sailors know that we have mission oversight of that and we're going to maintain the requirements.

**CAPT Nelson:** We are the first and only fully integrated federal healthcare center—go figure—I have about 2,200

veterans, GSs that work for me, and about 830 to 840 active duty that supports recruit training, commands missions being the only boot camp to support the United States Navy. And then, obviously, about 40% of the Navy's A Schools are located at Great Lakes as well. It's generally about 6,000 students that are there, and maybe up to 10,000 recruits at a time, depending on, sort of, the flow of recruits during the course of the year.

Similarly to what Ray has said, we've got a population that comes through with about at least 40-45% that have never seen a dentist before. We generate about \$50 million of dental care each year. I tell people it's the largest dental clinic in North America. It might be the largest clinic in the world, I don't know, because obviously the Marines are split in two places. The Army, I think, got four or five boot camps as the Air Force has multiples, too. So, it's a huge dental product line. And then again, similarly for medical processing and initial dental screening, we have four days that we work during a ten-week boot camp, so there's a lot to get done. It's not something that you can send people out to the network, to a dentist, to get their dental care done with the constraints of the timeline, so it's challenging.

The other big thing that we see is we see tremendous amount of mental health attrition. The Navy, interestingly enough, has about double the mental health attrition rate that Marine Corps has, and we see a lot of people with adjustment disorders, we consider conditional suicidality, and we have a 32-bed in-patient mental health unit, which is always full. And then in general we probably have about another 40 recruits and students at any one time that are out in town, and so we're also trying to work through the process of getting those people separated quickly. I think Ray, your guys' times down in Beaufort, you get people on about nine days; for us at Recruit Training Command, it takes us 29 days because you guys do entry level separation. We're doing a lot of CND work for our population. The other

thing that's interesting is the Navy's approach, and we try to educate our line counterparts, is that recruiting quotas are based on who gets to boot camp, not who finishes. And then the Marine Corps has a different tact, so we've been trying to, also, socialize that with our admiral at command, our Naval Service Training Command, because she had the direct line, obviously, of the Chief of Naval Personnel, who owns our Navy Recruiting as well. So, there's definitely some challenges there in terms of compressed timeline, access for people, because obviously you can't send recruits out on the town. We do have a robust network, as I said, for mental health admissions.

Other things we've worked hard on is our LIMDU process. We just had our visit and we got, I think, really, really sort of glowing comments from BUMED. But we do a Page 13 notifying people of their requirements and participation after they got a schedule at 60 days prior to expiration, and also to be seen by 30 days. And then we have a coordinator who really is a VA employee who's just done a super job at helping manage that population. And again, we're happy to share that information.

Again, I think some of our personnel risk that was asked of us in terms of what happens when we mobilize people? Because we have, you know, two-thirds of our staffing is VA, I think we have a little less risk in terms of if we have to set people out to deploy. We'd had to do some requests to support the COVID operations and restriction of movement. The other thing, too, I think, is that it's a really—I think I've mentioned to you, Admiral Via, that it's a flash to the bang in terms of proximity to Big Navy. It's pretty wild. And again, to have a lot of access for Chief of Naval Personnel.

**RDML Via:** So, we're going to move over to the outside. It's a similar type question, but I'd ask you to focus on two different things, maybe. We kind of heard how they executed and what they're up against, but the two things I'd ask you to focus on, really, is you guys look at force generation to force preservation in the OPS forces. Obviously, we've got blue and green on both sides. The thing I'd ask you to really hit is, number one: much of this is DHA's mission. You're both dual-hatted, but where do you see the risk there? Where do you see the opportunities there? And what things do we need to know as a collective body that we're

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***"We generate about \$50 million of dental care each year. I tell people it's the largest dental clinic in North America. It might be the largest clinic in the world."***

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ensuring we're monitoring and measuring and maintaining that oversight? I'd ask you if you could get that along with your other talking points I know you've thought of, so you can choose who goes first.

**CAPT Allen:** I'm at Jacksonville, and Jacksonville's mission for the last 80 years has been to support the fleet. It really hasn't changed in 80 years. So, we can talk about who's and what's mission, but the ECH 4 level, my mission, whether it's subs in King's Bay or surface ships in Mayport is to support the fleet and to build excellent doctors that we can send out to the fleet. That is always the same and it doesn't matter if you call me an MTF commander or an NMRTC CO or am I a market director, that mission is always the same. And as I said, I only have DHP dollars to make that mission, and there may be other dollars somewhere else.

And if you've ever read *Good to Great*, we are really great at that and that's what we have to focus on, and we're probably going to have to sell some paper mills. There's some paper mills out there that we're probably going to have to sell, and so my job is to communicate that to, whether it's Admiral [John] Spencer or the commodore, what is the risk that has been assumed on their behalf and what is it that I'm not able to do? And you're right, it's only DHP dollars doing that. And so as I continue to look at that in our market, it's do I create MOUs, who've we've done some really good work with that to make sure that I get this OP forces doctors and IDCs into my building when I can to give them a joint commission accredited space. And so it's been taking a real hard look at what we always do and then working where the seams are with DHA to communicate that up to you and up the line and say, "Here is where the seam is and here's how I'm dealing with it, but we're about to break one way or the other." And so I think we've done a good job of making sure as a dual-hatted person to keep those lines of communication, but you know, it's interesting, always to talk to the line commander who said, "Well, why can't you give me nurses and front desk clerk to support the sub-IDCs," and frankly that is not what my DHP dollars go to. It's the right thing to do, potentially, but I don't have the dollars to do that, and I can't hire. I can't hire more nurses. Even if you gave me the money, half the time I can't hire them. So, these are the resources;

that's how our manning shapes out. And I'll let Liz talk.

**CAPT Adriano:** Our mission at Cherry Point is to keep the warfighter in the fight. A big part of our mission is installation support and this is intimately intertwined into all of this conversation, and I'm responsible for that because I have IH that space doesn't have and I have occupational health that space doesn't have. And it's super challenging because I'm losing people, not to divestitures, but just to this general attrition. The 803 didn't help, so love my Marine Corps brothers and sisters, but them taking 803 billets was not helpful. At our level we lost 12 or 13, which doesn't seem like a lot, but when I only have 150 active-duty people and they take 13, that's a big chunk, especially when it's EHO, it's a psychologist, it's 25—it's not 25 corpsmen, but we lost 12 corpsmen to that. And so it's very challenging to continue to meet that mission.

For those of you who don't know, the harriers are going away and the F-35s are coming onboard, and right now we don't know what that shift in numbers is going to look like at Cherry Point. Are we going to have the same number of people because some of those pilots are going to be cross-trained, but with new squadrons coming in, there will be an increase in the number of people that I have to support at the base, and we don't know how many that is yet. And I'm going to be expected to do that with less people over time. The number one and number two issue that the Marine Corps cares about on Cherry Point are mental health and the readiness. So, I have groups of folks that come in at all times, whole units that will come in at three o'clock in the afternoon and they'll need immunizations, right? And so we take care of that.

When I am down 25 corpsmen, and I'm down lab techs, and I'm down pharmacy techs, and I'm pulling from the Quad zeros that I have left, that makes it super hard to meet those other missions. And those people are not going to be replaced, like I've lost those bodies and I'm not going to get them back, so I know I sound like a Debby Downer, but that's the reality that we're working with. So, to your point about how do we mitigate that, sir, and how do we figure out how we're still going to meet the mission, because the mission doesn't go away, right? I can say I'm going to stop seeing retirees and I can say I'm going to stop seeing pediatrics, but family readiness is readiness, and so that's all

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part of our mission as well. So, how do we mitigate that?

We borrow from Peter to pay Paul. We pull corpsmen from the clinic to go over and staff the lab. We pull our quad zeros to go to the pharmacy and get on-the-job training. I just got an email from the psychology specialty leader a couple weeks ago that said, "Hey, I just want you to know that one of the psychology billets that you have is not going to be backfilled when that person leaves in a year and a half. How do I go to the base CO and say, "I know mental health is like your number one priority, but I'm about to lose another body, which means I'm not going to be able to take care of you as well as I'd like and as well as you deserve." Those challenges are going to keep coming, especially in a mental health community. We live in what Captain [Reginald] Ewing and I love to call a "hiring desert," and I know we're not the only ones. That's true in many of the places where we're all stationed, so it's easy to say, "Well, it looks good on paper. The community can support that." Or you should just be able to hire into that to support the active-duty folks that are leaving, but the bodies just don't exist. And so I kind of feel like that growing our own is part of the way we're going to get ahead of that, Sir. Thank you.

**RDML Via:** I'm going to turn it over to Admiral Kuehner. Before I do, I'm going to ask two or three questions. A couple things that I heard was number one: when it comes to that base OPS support mission, my question would be is it defined anywhere whose mission that is?

And then, my question is, and I don't need an answer today because I'm going to hand it over to Admiral Kuehner and move on, but when it comes to those shortages of all those capabilities you're in a little bit of a hiring

void, by the same token, do we do a good job? Or have we historically done a good job? Or should we do a better job? But at this time, I'm going to go ahead and turn it over to Admiral Kuehner.

**RDML Kuehner:** Good morning, I'm Cindy Kuehner. I'm commander of Naval Medical Forces Support Command, and if I haven't met you personally, I promise that my AOR touches everything that you do at some part of the life cycle of our product line. So, two of my echelon four COs are here on the panel. And if you've heard about programs like HPSP, DUINS, HPLRP, GME, Naval Post-Graduate Dental School, the predictive index. I just wanted to throw that out there so that you know I have another CO that affects our foundry, and specifically the professional and leadership development in Navy Medicine assets.

So, I want to direct my questions to both Captain [Anne] Case and Captain [Matthew] Hebert, so I'll start with Annie. Annie, in your role as Navy Medicine Training Support Center, or "TSC" as we call it by short, commanding officer, you provide operational and administrative control over the staff and students assigned to the TriService Medical Education Training campus or METC aboard JBSA, Joint Base San Antonio. In that capacity you cover hospital corpsman A School, 20 "C" Schools, six officer programs, three detachments, which are geographically located at Portsmouth, Lejeune, San Diego, to clinical rotations. So, let's focus on hospital corpsman basic. There's a lot of—when I'm in San Antonio people think, "Oh, you have a Corps School?" Well, so we're getting into that a little bit. So, with those hospital corpsmen, everyone uses them, you've heard the ACMC [Assistant Commandant of the Marine Corps] yesterday, can't live without them. They're perfect when they arrive. But let's go a little bit deeper than the ACMC's accolades. Upon graduation, 25% of those corpsmen go to C School, 10% test to FMTB. 60% PCS to an MTF/NMRTC—some CONUS, some OCONUS. And 5% head on to the C School pipeline. Navy Medicine's focus is readiness. So, given the complexity of your operations, the continuous throughput of students and the dispersed geographic distribution of your assets, why do HMs arrive at their first duty stations, whatever those are, without a lot of clinical experience? Does it meet the expectations of our fleet? And why can't they get a lot more

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***"When we hand over that hospital corpsman basic, it truly is basic, and the expectation is that wherever they go, we are just continuing in that investment, in professional training and leader development."***

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clinical training as a result of the outputs there at hospital corpsman A School?

**CAPT Case:** Great question, ma'am. Good morning, leaders and peers. Just to help you understand what hospital corps basic is, it's not Tri Service anymore. It went single service in 2017. It's 14 weeks long. Fourteen weeks that I get to take from what Tom has not weeded out from street punk to someone that you need to start an IV with bullets flying over their head in 14 weeks—14 weeks. I'm sorry, 14 weeks. We didn't stop in COVID. The only thing that stopped was moving them in 2020. We provide that foundation in 14 weeks to understand what anatomy is, because again, I get anything from street punk that barely did well in high school to—there's some of them that I've handed over dean certificates and they've already got degrees. They just decided they wanted to be a corpsman. So, I've got the smartest to the non-smartest. We provide that foundation. So, the final couple of weeks that they're there, they go through shipboard training. We've got a mockup of a ship—the sirens, the whistles, everything—and then they get to litter-bear them into a ward and they get to go through the nursing care; they get to simulate everything. And then they also go through a week of TCCC where it's white sirens, etc. in that operational field environment. So, if they come to you as warriors, that's why, they've been to that teacher, came here as warriors, then I tell them they have to work at patient admin. And I warn the students about that, too, "You might have to work in patient admin." But some NMRTCs are going to train you. So, that teacher will see the pass/fail—thankfully it's 97% pass rate, so that's the clinical that we do. We have 14 weeks, and the curriculum was written by the experts out there and certified by her staff at NMRTC. We have to teach the

curriculum—14 weeks—we cannot deviate from it. So, there is no clinical. There's clinical at the phase 2 of the C Schools, but otherwise yeah. And by the way, to pass HTB, it's 70%, so some of you are going to get the 71 percenters. You're not going to get the dean's list, so it's on you.

**RDML Kuehner:** When we hand over that hospital corpsman basic, it truly is basic, and the expectation is that wherever they go, we are just continuing in that investment, in professional training and leader development. It doesn't mean that's a forever thing and can't ever be modified, but if there's a new requirement, it's not going to happen overnight. So, if there's something specifically that isn't being produced—and I will tell you in another hat that I wear, sharing the inner-service training operations to look at that with the services at the METC campus, we are very cognizant of the fact that it's not just a matter of throughput. We need to make sure that we are delivering the quality and expectations, and so we're looking at ways to measure that more objectively in terms of what the fleet and the Air Force and the Army need from the basic programs, which are currently service-specific. I'll come back to you if I get time for a leftover question, but it will be TF. The question is just how are we ensuring that the basic program is keeping pace with a pivoting objective towards operational readiness? And so, I know she has answers, but we'll come back. Let me get to you, Matt, so we don't run out of time. Our goal is to leave enough time to answer some questions.

So, Matt, your home's in Pensacola, Florida, and you're an ECH 4 commanding officer of Navy Medicine Operation and Training Command. You produce operationally ready medical forces. You execute programs of instruction in undersea surface, aerospace, line aviation, expeditionary medicine, special operations, and healthcare support. You also manage 17 training centers, 103 facilities, 16 geographically discreet locations training over 25,000 students annually. You cover novel and evolving initiatives such as HMTT. UPENN, the Navy Trauma Training Center in L.A., as well as our familiar IDC programs, the Navy Aviation Safety and Survival training for aviators, aircrew and other service



and international aviators. That's not much, is it Matt? You just get on with that. Why are you here? You've got stuff you should be doing. Tell us about some of the elements that drive force generation and force development through NMOTC's portfolio.

**CAPT Hebert:** Thank you, ma'am, and I should probably be doing email right now, or something like that. I'd like to add a couple of other extra things to what she just said and that is that NMOTC is an incredibly unique. There's probably not a product that we don't produce for the fleet. There's not a product that we don't produce for Navy Medicine, but we also produce product for our line. We are the most geographically disbursed with seven detachments. We are 100% readiness. That's our mission. We are operationally diverse. We teach over 66 courses of instruction.

Our detachments have learned, especially during the COVID environment, that had to apply really innovative and cost-effective learning solutions that have fully leveraged the technology that's available. Also, we have partnered and created joking initiatives, and we're able to respond pretty quick to validate and resource our training requirements. So, that is very unique. It tends to move and fluctuate all the time. Our training programs are reviewed and evaluated on an on-going basis.

Last, but not least, we will produce and upgrade Navy Medicine's weapons systems—that's our people—through our leadership, our operational, professional, and our occupational education and training solutions that I just mentioned. And we do this throughout the full tenure of all of our member Naval service. So, think of us, once our graduates come out of Corps School, and this is just on the enlisted side, we are the graduate level degree schools that you'll see that are going to the operational commands. We produce very little in terms of direct support for the

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***"NMOTC is an incredibly unique. There's probably not a product that we don't produce for the fleet. There's not a product that we don't produce for Navy Medicine."***

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NMRTCs; however, it does roll back into a lot of our OPs and programs. I see a lot of wings out there, UMOs, you're all products of our schools as well. •

## **SGLS Leadership Symposium Agenda, 16-18 May 2022**

### **May 16th:**

- State of Navy Medicine
- Fleet Marine Force Panel
- Guest Speaker: Assistant Commandant of the Marine Corps (ACMC)
- MSC Change of Charge Ceremony
- Human Capital Resourcing and Talent Management
- Managing the Unexpected: Overcoming the Challenges of the COVID-19 Outbreak
- Guest Speaker: Secretary of the Navy

### **May 17th:**

- Resources Review
- Navy Medicine Foundry Panel
- Mental Health
- Research & Development (R&D)
- Fleet Panel
- State of the Enlisted Force
- Diversity and Inclusion, EEO and MEO

### **May 18th:**

- Future Platforms
- Organizational Design for Operational Medicine
- High Reliability Panel
- Navy Reserve Medicine Strategy

*\*\* Video recordings of individual panels can be made available upon request by emailing Navy Medicine Retiree News.*

# Navy Medicine R&D Panel

## Current R&D Highlights



**CAPT Yablonsky:** My name is Abby Yablonsky, the Deputy Commander. I'm filling in for [CAPT William Denniston] today as the moderator, and after we hear from all our commanding officers at our research commands, I'm also going to be talking about the research capacity at the Naval Medical Research Center. Since we don't have a lot of time and there's eight of us who need to speak, I'm going to provide a brief overview and then we'll turn the mic over to each of our commanding officers and I'll introduce them, and they will have three minutes to talk, and then we should have lots of time for questions, so we want to make this as dynamic and exciting as possible.

What is the mission? Our mission is to conduct research and to provide surveillance to enhance the health of the readiness and the performance of our military personnel across the globe. Our vision is to deliver solutions, that's right, solutions, that enhance readiness and project research power in support of U.S. Naval superiority. Next slide.

So, who are we? We are comprised of Medical Service Corps, Medical Corps, Civilian Corps, Hospital Corps, and a very few Nurse Corps. This mix of individuals provides synergy of diversity and thought and enables world class science. Platforms, we have five commands that are in the United States. We have three commands that are overseas. To steal a quote from Admiral [Tim] Weber when he talks about Naval Medical Forces Pacific he says, "The sun never sets on Naval Medical Forces Pacific." I would say the sun never sets on Research and Development. We are all over the globe.

Power—our intra-connected web of research commands is really the basis of power production and rapid response to emerging threats. We've talked a lot about embracing the red, both yesterday and today. And in research we literally do that every day. Why did we not get the result that we wanted? What went wrong? What went right? What do we need to do better? Research is a process of constantly asking questions and then asking them again—that takes time; it also takes money. Captain [Stephen] Marty mentioned earlier \$50 million that we will receive in funding every year. I will tell you that for our entire research commands across all eight of them, it takes about \$250 million to do what we do every year. It is an expensive proposition, but we hope to show you the variety that we bring.

This is our organizational chart, and you can see on the chart NMRC, Naval Medical Research Center, Headquarters Command for the Research and Development Command, we fall under the Naval

## PANELISTS



**CAPT ABIGAIL YABLONSKY**  
**MODERATOR**  
XO, NMRC  
SILVER SPRING, MD



**CAPT WALTER DALITSCH**  
**PANELIST**  
CO, NAMRU-D  
DAYTON, OH



**CAPT GERALD DELONG**  
**PANELIST**  
CO, NAMRU-SA  
SAN ANTONIO, TX



**CAPT DENNIS FAIX**  
**PANELIST**  
CO, NHRC  
SAN DIEGO, CA



**CAPT FRANCA JONES**  
**PANELIST**  
CO, NAMRU-6  
LIMA, PERU



**CAPT MARSHALL MONTEVILLE**  
**PANELIST**  
CO, NAMRU-3  
SIGONELLA, ITALY



**CAPT KATHARINE SHOBE**  
**PANELIST**  
CO, NSMRL  
GROTON, CT



**CAPT JONATHAN STAHL**  
**PANELIST**  
CO, NAMRU-2  
SINGAPORE

Medical Forces Pacific Region, and again, we've really appreciated Admiral [Tim] Weber's support and we look forward to working with Admiral [Guido] Valdes next week when he takes over on Friday.

Before and during the pandemic, our leadership worked to develop a strategic plan. In this process, we needed to identify our core capabilities so that we could communicate to both our internal and external colleagues and customers what is our value? What do we do? I would posit that most of you in the audience did not know that Navy Medicine had a dedicated research capacity prior to COVID, and so now that we are moving on with other things post-COVID, we, as Naval Medical Research and Development, need to be relevant to our colleagues and our customers and stay relevant.

So, our six core capabilities:

- Infectious disease: We identify and mitigate disease threats to war fighters by pathogen characterization, disease discovery, and diagnostic development in clinical trials.
- War fighter help: We study physical and cognitive performance across all military operational environments—we're talking aerospace, submarine, diving, and maritime and land domains.
- Combat casualty care: We develop new technologies and treatments to protect, resuscitate, and care for our combat casualties.
- Bio Effects: We study limits and counter measures for exposures to directed energy, blast, motion, acceleration, spacial disorientation, altitude, heat, cold, noise, environmental and atmospheric stressors, and fatigue. That was 11 in case you were counting.
- Health: We study health outcomes—behavioral interventions, muscular and skeletal injuries, environmental stressor, and lifestyle factors that affect the health of our war fighters and their families.
- And research support: Each of our commands has capabilities in research administration, contracting, fiscal management, and execution of agreements. Next slide, please.

So, where we are. We are all around the globe. I am going to start by introducing Captain Dennis Faix, he is the commanding officer at the Naval Health Research Center (NHRC) in San Diego, California, and he is going to talk about his command.

## 20 Navy Medicine Legacy

**CAPT Faix:** Thank you. Good morning, SG, DSG, Force leaders. My name is Dennis Faix. I am a preventive medicine doc and truly honored to be the CO of an NHRC located in the beautiful and always sunny fleet concentration area of San Diego, California, with a view to INDOPACOM and keeping our eye on the ball there. I don't have much time, so there are really two things that I hope you can remember about an NHRC after my short brief. One is that we're fleet focused, and number two is that we can be quite agile.

Fleet focused—we regularly ask ourselves what have we done for the fleet today? And I'll just give you a couple of examples of how we've answered that question just in the last two months. First will be United States Marine Corps Infantry Marksmanship. Picking up on some work that was actually started in NAMRU-Dayton, and NHRC led research team developed, tested, fielded, and improved marksmanship course of instruction that actually resulted in demonstrated and sustained increased in speed the first shot and second shot and all subsequent shots and increases in accuracy, so literally increase in the lethality of the individual Marine and the small rifle squad. To the general items, TCOM called it the biggest doctrinal change in marksmanship training in over a century, and that's an impact of R&D, really nice.

Yesterday, some of you may have noticed General [Eric] Smith was wearing an oura-ring, and he said he pays \$300 for it to tell him he didn't sleep well when he knows that. But, NHRC, working with NIWC, can put that at a wearable technology on every crew member on the ship and wirelessly connect that—thanks to NIWC that we can do that. Every time they'd walk by a laptop in the hallway or something it picks it up, and so basically what you can then give to the operational commander is a near-real time dashboard of how the crew's doing—fatigue, sleep, stress—those kind of physiologic markers if we had that, and that can go into the operational picture of the commander.

So, those two examples are real research. Research is a deliberative process that can be slow. We have to go out and—Abby mentioned—we have to go out and get our money. We have to write proposals; we have to get IRB approvals; we have to integrate with the fleet to try and do these studies. And it can be slow, but we can also be very agile under the right circumstances. Not everything that we do is protocol-driven. We have a lot of expertise in R&D



and we can leverage that to react quickly under the right circumstances.

**CAPT Yablonsky:** Thank you very much. Let me introduce Captain Katherine Shobe, the Commanding Officer at the Naval Submarine Medical Research Laboratory in Groton, Connecticut.

**CAPT Shobe:** Good morning, everyone, SG and DSG, Admiral Via, you are honored to visit us about a year ago at the Naval Submarine Medical Research Laboratory, or NSMRL in Groton, Connecticut—technically at Naval Submarine Base, New London, even though we’re physically in Groton. And last year we had the honor of celebrating our 75th anniversary. You saw a clip of the video, in the initial kick-off video, yesterday morning, and we were honored to have the SG and Admiral Weber attend that as well. Two things to point out before I start talking about some specific efforts, even though submarine is in our title, our work encompasses all undersea war fighters—that’s submariners and divers, and you’ll even hear a little bit about some of our work that directly affects the Marine Corps. We’re very operationally focused—a lot like Naval Health Research Center, and we conduct with research and provide direct-support to the operational forces.

Some specific efforts I’d like to highlight in this forum is ever since we were established in World War II, we have been the lead agent in conducting the psychological readiness for all submarine trainees—officer and enlisted. SUB school is located on Naval Submarine Base, New London, and the assessment has changed over the years, but most recently, two months ago, Admiral [William] Houston with TYCOM agreed to our recommendation to transition the submarine psychological assessment screening to our own in-house developed screening. And the cool part about this is it’s less of a screen out-process, and it’s more of a screen-in process working with Sub School in the Warrior Toughness Program and embedded mental health and the clinic mental health providers.

So, the assessment includes two parts—it’s still screenings for the psychologically disqualifying factors, but it also screens for the nine clinical personality, motivation and student development factors as well, realizing that we’ve got limited resources, limited number of people on the Submarine Force. We want to keep them in and make sure they’re fully developed.

Another thing related to Submarine Force, in 2015, they finally transitioned from an 18-hour watch standing bay to a 24-hour watch standing bay, hard to believe, but that was based on decades of work at NSMRL. And we still continue to conduct that type of research looking at sleep quality, sleep quantity, and developing fatigue countermeasures—countermeasures that are feasible on submarines. And then transitioning to our diving and hyperbaric research, obviously a very high-risk evolution, we conduct war plan on how to reduce the risk of DCS (decompression sickness), oxygen toxicity and thermal stress. Specifically, we’re looking at novel ways to predict oxygen toxicity, looking at biomarkers. And we have a very robust program informing the fleet on how humans are affected by underwater sound and blast, tools, unmanned vehicles. And we are the lead in developing the safe stand-off distances and exposure guidelines for our undersea warriors. Great way to do this because we have some cool features at NSMRL. We have a dive locker. We have a hypo/hyperbaric chamber undergoing a \$10 million renovation right now. We have an indoor test pool and then we have a dive boat for open water diving.

Finally, I wanted to touch upon our Hearing Conservation Program, and this is our program that directly supports the Marine Corps, even though when it initially stood up, it supported the submarine force. We are the subject matter expertise in conducting researching on hearing conservation, audiology, psycho-acoustics, both focused on maintaining the health of Marines, but also trying to increase the operational performance of the Marines. So, how can we best provide hearing protection devices, ensuring they’re fitted correctly and used correctly while maintaining the ability to maintain that situational awareness, whether it’s through communications or being able to localize sound. They’re currently doing lots of studies now with the School of Infantry East and live-fire training, and we’ll be spending a lot of time down there, and if any of you in that area, I hope you get a chance to see them.

In summary, we’re very privileged to support the submarine, the Diving Force and the Marine Corps Force and look forward to your questions.

**CAPT Yablonsky:** Thank you very much. Let me introduce Captain [Gerald] “Troy” DeLong, Commanding Officer of the Naval Medical Research Unit, San Antonio.

**CAPT DeLong:** Good morning. I will start out with some of the comments, paraphrase, from some of our leaders from yesterday. How are we going to hold patients for two or three, or seven days, concerned about dental surgery, readiness. How do we get a higher survivability at the IDC level versus surgeon that you may not have access to and SOCOM, blood products that don't need to be refrigerated? Keep in mind that we also have to be concerned about those that freeze when you're trying to use them. So, those are all things that, at NAMRU, we are working on. We have combat casualty care, and so certainly INDOPACOM Arctic AORs are of interest. So, we've got quite a few blood products that were, apparently, in development, some further along with the FDA than others to try to help us out in those areas where, certainly, we haven't operated at a frequency that we will in the future, most likely.

Some other things that we have within combat casualty care, we're the only DoD in poly-trauma and non-human primate model. So, we're able to do some very unique things there. So, we do a lot of hemorrhaging projects. We come up with a lot of innovative products, techniques, and then also a lot of folks call us for information. So, those are ways that we might be able to serve you.

We also have cranial maxillofacial research that is pretty interesting. So, a lot of the dental materials, they start out as dental materials but then, because we do medical research and dental, we find different uses for them, whether it's in a matrix or whether it's an antibiotic hydrogel, or we're looking at applying bandages and starting treatment right there in the field. So, most recently we met with Admiral Freedman about a wrong-site dental surgery project that we're starting up there. So, we've got some areas of research there that are very unique. And then medical effects of directed energy, that's our third major line. And so it's kind of interesting—a few years ago, that was kind of mothballed, so it's been started up, maybe, three or four years ago, and of course, the interest in directed energy is very, very high right now.

So, we are housed with the Air Force, who does directed energy, weapons development, and then we do the medical side of it for treatment and identification of injuries. So, it's a pretty good partnership. We're located in an area where we have a lot of collaboration; although Army's combat casualty care stuff is not the focus of the Navy's, but it's a good environment down there, a lot of collaboration. I will

say this, in prior jobs where I've done research, we trained Marines in that capacity for bio and chemical detection. And so it was good because we had the upper hand in research side—did the training and found out what was going to be ruggedized for military use. So, those are some of the partnerships that we're looking to develop in San Antonio.

**CAPT Yablonsky:** Thank you very much. Let me introduce Captain Walter Dalitsch, the Commanding Officer of the Naval Medical Research Unit-Dayton in Dayton, Ohio.

**CAPT Dalitsch:** Good morning, shipmates, and Admiral. So, today's 313th day of my command, not that anybody's counting, but NAMRU-Dayton, primarily our focus is on human performance sustainment and enhancement and protection in extreme and toxic environments. So, picture yourself, for example, on the deck of an aircraft carrier with the full hazards there—the fuels, the fumes, the rotating props, the noise, the jet blasts—and also the extremes of the environment outside of the 1/10th the force of gravity and zero feet above ground level, so mainly aerospace realm on that side, but a little bit in the submarine realm as well. So, basically, it boils down to getting our operational warriors ready for anything the planet flings at you.

Two primary labs—the Naval Aerospace Medical Research Lab, focusing, again, on those extremes of flight, and the Environmental Health Effects Laboratory, which is the Navy's robust inhalational toxicology lab. As part of that TOX lab, for example, we paved the way for women on submarines when we were able to show that that recirculated air on submarines was no threat to young, reproductive-age women.

Three command priorities. First, is printing and marketing, a lot of the fleet, even though they come to us and are our customers, don't know what we do and what we have and what we can provide them. I have two full-time PAOs who, I guarantee you, are fully employed. Collaboration is second command priority—both internally between our two labs. For example, the recent physiologic episodes, both our human research side on the NAMRL and the rodent research on the EHEL side, we're able to collaborate for physiologic episodes. We collaborate with several dozen institutional, educational and civilian partners, such as FAA. Our biggest partner is right across the street, the Air Force's 711th Human Performance Wing, they have the DoDs only centrifuge. We have the western hemisphere's only Krak-

en—the programmable six-degree human platform device.

And then third command priority is right-sizing. This is not your father's right-sizing of the 90s, which was another term for downsizing. This is putting the right people with the right skills and the right education in the right place to do the right science in the right labs with the right equipment. I have 150 total people—only 15 are active duty—no enlisted, so about 135 of my personnel are civilians, most of whom are contractors with multiple degrees. At the end of the day, it's all about human performance, sustainment and enhancement in protection in extreme toxic environments, and that's NAMRU-Dayton. Thank you.

**CAPT Yablonsky:** Thank you very much. Let me introduce Captain Jonathon Stahl, Commanding Officer at the Naval Medical Research Unit Two in Singapore.

**CAPT Stahl:** Good morning, Admirals and shipmates. NAMRU-2 has operated in the Indo-Pacific region since the Second World War. Our principal focus is to inform military medicine by implementing smart, agile surveillance for the far-forward characterizations and respond. Our command operates in a unique problem model, currently we are headquartered in Singapore with projects in six Southeast Asian and oceanic regional countries, as well as other parts of Asia. We depend on unique, strategic partnerships to accomplish our mission. This goes very much to what Captain [Franca] Jones mentioned yesterday that the overseas labs have the ability to strengthen uniquely international partnerships to what we call a soft-power approach. Our partnerships include host-nation militaries, ministries of health, academic institution and NGOs, and we are funded through various sponsors and grants. Our funding model is similar to the OCONUS labs—it's competitive and complex. In the end, the mission of our overseas lab is force health protection and combat readiness to a medical intelligence, but our data that we collect with our host nation partners is open and shared and often helps guide public health policy in the nations where we operate. We offer advance capacity and capabilities in many areas where we engage—in many countries where we engage—as well as scientific expertise that enables the pathogen characterization and discovery that we do. In addition to the bio surveillance that tends to be the bulk of our mission, our priority pathogens, our research, also includes testing and evaluation of advanced diagnostics and therapeutics of-

ten through clinical trials. The emphasis of our scientist is on rapid, point-of-need approaches, and I'll stop there and turn it over to Captain Monteville.

Let me introduce Captain Marshall Monteville, who is the Commanding Officer of the Naval Medical Research Unit Three in Sigonella, Italy.

**CAPT Monteville:** When we started in Sigonella, we didn't have reliable office space or network connectivity. We worked out of what my XO called the FCOO, the Food Court Operations Center, using the Taco Bell wifi. I'm not joking. Then COVID hit, which created more challenges. Despite those challenges, the NAMRU-3 crew met the command mission supporting our customers in Africa on the EUCOM and CENTCOM, providing force health protection dated guidance.

NAMRU-3 no longer has a brick and mortar laboratory. After being in Cairo, Egypt for over 75 years, the NAMRU-3 facility was closed and the headquarter element relocated to Naval Air Station Sigonella in 2019. However, we do continue to have detachments in both Ghana and in Egypt. Personnel throughout these detachments belong to NAMRU-3, but they also fall under chief of mission, as they do in both of those other locations. We also have a small footprint in Djibouti, and work closely in cooperation with the EMF.

Because we don't have a central physical laboratory of our own, we must rely on partnerships to support the combatant commands and ultimately the war fighter. In Cairo, we collaborate with Ain Shams University and have become partnerships with the Ministry of Defense on the compound that used to be NAMRU-3 facility. Egyptian scientists are also involved in numerous studies in Jordan, and as far away as Liberia. In Ghana we have partnered with the 37th Military Hospital in Noguchi Memorial Institute in Accra to do that research throughout the region. With these partnerships, NAMRU-3 scientists collaborate with host nation scientists to seek out funding opportunities. NAMRU-3 is then able to identify disease threats that may be circulating in the areas of interest, and then we can inform our customers and assist with mitigating these risks.

In direct support of the war fighter, our laboratory at Camp Lemonnier in Djibouti is the only forward permanently positioned DoD asset in the AOR. We have long standing research projects and we work with the



EMF to identify potentially emerging disease threats. Since COVID, NAMRU-3 has responded to 14 separate requests for support and requests for forces. These include, but are not limited to, establishing the operational risk reduction, COVID-19 testing program in cooperation with the EMF. At least one NAMRU-3 sailor has been deployed to the camp continuously since March of 2020 providing over 35,000 results for 27 deployed units. In closing, we've operated outside the box for sure since at least 2019. We are strategically located to support the war fighter and three COCOMMS at real time. Taken together, our efforts support the SGs four Ps, especially power—being forward in austere locations during challenging times. And a special shout out if he's in the crowd today, MEDEVAC NAMRU surgeon Captain Woodson, he's been very supportive of our work too, so thank you.

**CAPT Yablonsky:** Thank you very much. And let me introduce Captain Franca Jones, the commanding officer at the Naval Medical Research Unit Six in Lima, Peru.

**CAPT Jones:** Thank you very much Surgeon General, DSG, admirals, colleagues. Five Ws, who are we? Naval Medical Research Unit Number Six in Lima, Peru. We are the only DoD command in South America. We do have 15 active duty. We are billeted for five GS and we have over 300 locally engaged staffed both in the flavor of locally engaged staff State Department that we fund as well as contract. We are located in three different locations within Peru on Peruvian Naval Installations going back to the strategic partnerships piece. In Lima, Peru, we are actually on their—what was the National Naval Medical Center base. In Iquitos, in the jungle region, we are on the Peruvian Clinical Naval, their local Peruvian Naval clinic in the Amazon region. And then in Puerto Maldonado, we're on a small line Navy base there.

We are also partnered with Joint Task Force Bravo, and in Honduras where we have a small lab there and we do some activities very closely related with JTF Bravo personnel, as well as in the local Honduran Ministry of Health, Ministry of Defense. We were established in 1983 with a MOU between the surgeon generals of the U.S. and Peru, which is why we have that close strategic relationship with them.

And so why? Why do we exist? All three of the overseas labs exist to do infectious disease work in areas where

infectious disease occur, so that when we are sending our forces into those areas we, one, know what's there. We know what we can use to treat them or prevent them. We are looking at antimicrobial resistance—not just in the naturally transmitted pathogens, but also in areas where wound infectious and trauma infections and looking at those so that when we go downrange, we know what's there and what we can use. And then as I mentioned yesterday, we have that piece that in doing so with our host nation partners, we are indirectly doing global health engagement on a day-to-day basis. So, within NAMRU-6, we are operating in 11 countries in Central and South America, and all of those relationships are critical.

So, real quick on the SGs four "Ps." Our platform is a vast network of research collaborations, whether they are fixed labs or whether they are partnerships with hospitals in the area, that is our main platform to do, kind of, two main things—infectious disease surveillance and diagnostic development, so we're talking about prolonged field care; we're talking about people that are potentially not going to be in an MTF. Can we find the latest, greatest diagnostic devices that can be pushed far forward so that on an infectious disease standpoint, you know what it is, you know what you can use to treat it at the point of care, or point of need as Captain Stahl was mentioning? We also have the only animal facility that is owned and operated by Navy Medicine. We use that facility to test different products on—mostly on the monkey model for diarrheal disease, which is still a big problem—as well as looking at malaria and dengue fever, medical countermeasures in that model. And then NAMRU-6 was the only laboratory worldwide to develop the first mosquito colony of a local mosquito. I'm not going to give you the genus and species, and in fact, we are the only DoD lab that has that colony up and running and we were only the three in the entire world. And we have that? Because we're using that to test insecticides. We're using that to test insecticide resistance, which is a problem, so that we know we can treat those uniforms and what's needed there.

We're projecting power through those collaborations—military, academics, industry, etc. And then we are optimizing people and performance. We were implementing get real/get better to ensure that our organizational structure is in alignment with the mission, with alignment with SOUTHCOMs mission so that we can support that, and the

Navy, and we've done some process improvement to move forward on that. So, with that, I will turn it back over to Captain Yablonsky.

**CAPT Yablonsky:** Thank you, very much. So, I'm going to finish by talking about Naval Medical Research Center, which focuses on developing products and solutions for the war fighter. So, we operate four biological weapon detection labs that are globally deployable upon 24 hours notice to directly support our special operations community. We also support special operators with hands-on training from our scientists on topics ranging from biodefense agent detection to emerging technology and DNA printing. NMRC was able to deploy these assets, the equipment, the re-agents and our trained personnel when Pacific Fleet requested shipboard COVID detection and diagnostics, and we were there to detect the first case of COVID-19 on the USS Teddy Roosevelt. NMRC provided additional rapid response teams to the USS America, New Orleans, NIMITZ and our two hospital ships—USNS Mercy and Comfort. Our scientists worked to understand and mitigate the effects of blast exposure in DoD personnel from sources such as IEDs and heavy munitions firing. In addition to having the technology and the equipment to simulate blast exposure in animal models, we also have chambers that simulate the undersea environment encountered by divers, submariners, and special operators. NMRC identify potential hazards of increased carbon dioxide levels during disabled submarine rescue operations and proposed procedures to leadership to mitigate this risk. NMRC also uses specialized flight simulation chambers to model the environment the wounded service members are exposed to during aero medical evacuation, providing data to determine the effect that temperature and pressure changes have on wound healing. We monitor wound healing at the pressure of a helicopter—around 5,000 feet—and also up to cruising altitude of planes at 30,000 feet.

Our CHARM study, or COVID-19 Health Action Response Marines, which Captain Via's mentioned earlier—and you may have heard of—was rapidly stood up at the onset of the pandemic response to a Marine Corps leadership lead, to understand that bio-transmission in their failing health, middle crew, population. And we continue to investigate the long-term effects of COVID-19 in its population.

Additionally, NMRC provides diagnostic test results that our Navy Infectious Disease Diagnostic Laboratory, the NIDDL. Some of you may have heard of it. This asset has supported over 27 military treatment facilities and DoD entities, including shipboard platforms on the Eisenhower, the Kearsarge, and the Normandy. We have completed over 60,000 COVID PCR tests to date—60,000—while continuing to provide diagnostic testing for dengue virus, chikungunya virus, Zika virus, Rickettsial agents, Lyme Disease, and influenza A and influenza B virus. NMRC continues to rapidly sequence and identify SARS COVID2 variants using one of the most sophisticated genomic sequencing labs anywhere, serving as DoDs East Coast hub for expanded SARS COVID2 sequencing. We have sequenced and analyzed 4,864 samples in-house, supporting over 13 in DoD entities including MTFs, the Fleet and Marine units. Concluding, we work in uncertainty, and we venture deeper into these and other critical areas because what we need to do is provide solutions to the challenges that need to be solved for our military. we take an expeditionary approach to research from the lab to the line, and I would say that for all of our commands, and that doesn't just include where the research is physically being conducted, but how far we can move forward in studying complex problems and identifying solutions. So, at this point, we are done with the panel—what the panel is going to say other than your questions, but I would like to take pause here for just a second to express my appreciation to our research and development commanding officers who all do a phenomenal job with their teams and the amazing science that they do and continue to do in a very challenging environment. So, thank you all very much. ●



LTJG Ann Darby Reynolds (R) receiving the  
Purple Heart in 1965

## MSGT BOCCHER & DARBY

By Cynthia A.S. Haigwood Coyle, CDR, NC, Ret.



"It doesn't matter if the wound happened on the battlefield or off the battlefield," says retired U. S. Air Force Master Sergeant Adam M. Boccher, "The scars are deep, traumatic, and debilitating whether it is the result of a wound suffered in the line of duty during conflict, or if it is the result of sexual abuse or traumatic brain injury from a car accident or PTSD."

According to the National Council on Disability, "More than 1.6 million American service members have deployed to Iraq and Afghanistan in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). As of December 2008, more than 4,000 troops have been killed and over 30,000 have returned from a combat zone with visible wounds and a range of permanent disabilities. In addition, an estimated 25-40 percent have less visible wounds—psy-

chological and neurological injuries associated with post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI), which have been dubbed "signature injuries" of the Iraq War."

The Defense and Veterans Brain Injury Center (DVBIC) reported nearly 414,000 TBIs among U.S. service members worldwide between 2000 and late 2019. More than 185,000 Veterans who use VA for their health care have been diagnosed with at least one TBI.

Adam Boccher entered the U. S. Air Force immediately after high school following in the service tradition of his father and grandfather who both served in the Army. Initially, Adam served in the U.S. Air Force Military Police. He pursued a Bachelor's degree in criminal justice, took the Military Investigative Police course and attended the



Air Force Office of Special Investigation (AFOSI) Academy to become an AFOSI agent. He deployed three times in 16 years (twice to Afghanistan and once to Iraq). Working primarily in the dark of night with night goggles and on counter insurgency missions, each deployment exposed him to high-risk situations, gunfire, rockets, and explosions.

In his first deployment to Forward Operating Base (FOB) Salerno, Afghanistan, Khost province, he and his team visited local villages in the dark of night to find and engage Afghans that were willing to cooperate with the U. S. military. The operations focused on "find, fix, track and neutralize" strategies. One night in a "snatch and grab" mission, he was standing atop a Humvee, when a rocket landed nearby. He fell head first to the ground. The gunfire continued for an additional two to three hours.

When stateside, as an AFOSI agent he was assigned to felony level cases, exposed to 200-300 autopsies, numerous traumatic events and violent crimes. He started to experience more signs of anxiety, stress and sleep disturbances, but did not understand that he should seek help. The problem began to take a toll on his professional and personal life. In 2018, he was admitted to the Traumatic Brain Injury (TBI) unit at Walter Reed National Military Medical Center, Bethesda, MD for medical evaluations and therapeutic interventions. During his 5-week stay, he experienced extraordinary care from all providers, but was particularly grateful for the nurses on that unit. He believes that they had a profound influence on the progress he made while there. "The nurses allowed me to speak without judgment, they provided emotional support and encouraged me to trust the process," he said. Adam was diagnosed with TBI, PTSD and RIM Sleep Behavior Disorder.

Capt. (ret.) Robert Koffman, who serves as the Chief Medical Advisor for the Warrior Canine Connection (WCC), suggested to Adam that he might benefit from the adoption of a WCC service dog. Initially, Adam felt unworthy as there were so many veterans in need; however, over time, he decided to apply.

Adam was contacted by WCC and invited to "interview" potential service dog candidates. There were three dogs available that day and it was the third dog named "Darby" (named after former Navy Nurse Captain Ann Darby Reynolds) that caught his attention. Adam stated, "Darby was a perfect combination of business and affection. We

connected immediately. She was tuned into my anxiety. Before Darby entered my life, I was extremely closed off, unable to open up to other people. I suffered from many episodes of anxiety that left me frozen in the moment. Darby knows how to disrupt with a 40-yard stare, she nuzzles my clenched hands to remind me to relax, and she snuggles with me to reassure me that all is well."

With time, Adam has been able to decrease some of his medications and he has been more interactive with his wife, children and even the public. As a family, they have been able to share many activities together including art projects where even Darby has done some painting on canvass.

Adam's quality of life is improving. In the summer 2022, he will complete a graduate degree in Human Services Counseling with Specialty in Military Resilience. He was thrilled that Darby came into his life and the fact that she was named for a Navy Nurse was just the icing on the cake. He takes a lot of pride in telling people about his "Darby Doo" and the woman whose name she bears.



**MSGT Adam Boccher with Darby**

Photo courtesy of author

Similar to the partnership between Adam and his service dog, Darcy, the Navy Nurse Corps Association (NNCA) has established a partnership with the WCC. The NNCA is an organization of current and past Navy nurses who have provided care for sailors, Marines, soldiers, and airmen to ease their suffering. Given that the NNCA's mission and values align with the WCC's program, the NNCA nominates Navy nurses for the WCC's namesake program. This program honors both the disabled veterans who receive a service dog and the veteran namesake for whom the dog is named.

When puppies are born into the WCC breeding program, they are given the name of a veteran namesake. After intensive training, some dogs successfully meet the highest standards of excellence in service and graduate to become service dogs; some dogs are used for the breeding program. Either way, these dogs contribute to a program that serves the needs of numerous disabled veterans. The NNCA was proud to nominate United States Navy Nurse Corps Captain Ann Darby Reynolds, retired for the WCC's namesake program.

CAPT Reynolds was commissioned an Ensign in the Navy Nurse Corps in 1962. She served as a staff nurse at the Naval Hospital Pensacola, FL, and was later sent to Camp Lejeune, NC to help with an influenza epidemic. When home on leave on Christmas Eve 1963, she received a special delivery letter notifying her of new orders to Navy Station Hospital Saigon, Vietnam. The following Christmas Eve, 1964, CAPT Reynolds was one of four Navy Nurses injured when a 200 lb. bomb detonated at their quarters in Vietnam. They were the first women to be injured and the only Navy Nurses to receive the Purple Heart during the Vietnam War. In 1988, after 26.5 years of active service, CAPT Reynolds completed her military career as the Director of Nursing Services at Naval Hospital, Camp Lejeune, NC.

When hearing of WCC Darby's graduation, CAPT Reynolds shared, "I feel so honored to have a service dog named after me. For years I have watched these dogs and how they have helped our wounded Veterans. The Warrior Canine Connection is a wonderful organization and very much needed."

Adam knew from the very start that his pairing with WCC's Darby was meant to be. "I can definitely describe

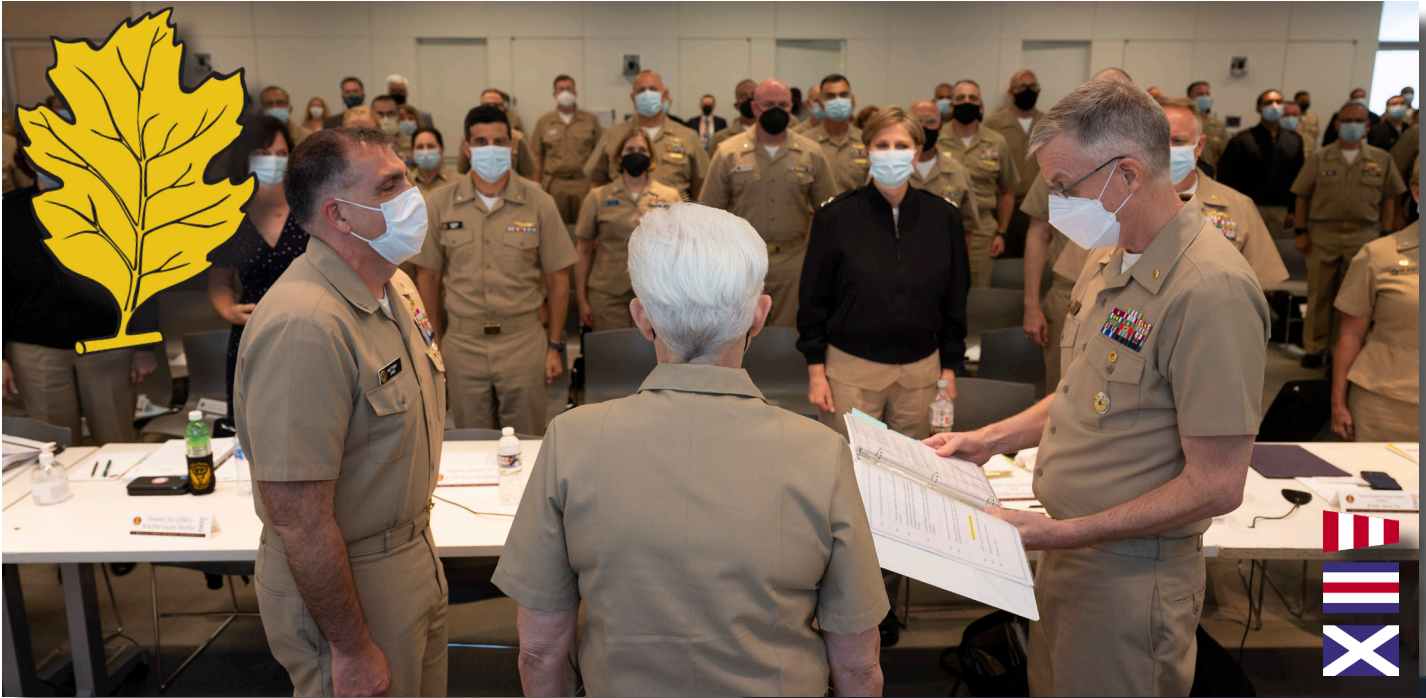
my matching process with Darby and why it was so special. It was all very natural and I remember going home that evening and telling my wife, 'I know Darby's it. She's it. She's gotta be the one!' When the WCC staff called and told me that Darby and I were matched it was just amazing. She's special. She's so special!" •



**For more information about the Navy Nurse Corps visit: <https://nnca.org>**

**For more information about the Warrior Canine Connection (WCC), visit: <https://warriorcanineconnection.org>**

# NEW MSC DIRECTOR



## NEW MSC DIRECTOR TAKES THE HELM

On May 16, 2022, RDML (sel.) Matthew Case (l) succeeded RDML Timothy Weber (r) as the new Director of the Medical Service Corps in a ceremony presided over by RADM Gayle Shaffer, Deputy Surgeon General  
Photo by MCI John Grandin

## MEDICAL SERVICE CORPS

### CHIEFS AND DIRECTORS, 1954-Present

#### *MSC Chiefs*

CAPT Willard Calkins, 1954-1958

CAPT Leo Elsasser, 1958-1962

CAPT Robert Herrmann, 1962-1968

CAPT Emmitt Van Landingham Jr., 1968-1973

CAPT Albert Schwab, 1973-1976

CAPT William Green, Jr. 1976-1978

CAPT Paul Nelson, 1978-1982

#### *MSC Directors*

RDML Lewis E. Angelo, 1982-1987

RDML Donald Shuler, 1987-1991

RDML Charles Loar, 1991-1993

RDML Stephen Todd Fisher, 1993-1995

RDML Edward Phillips, 1995-1999

RDML Phillip Van Landingham, 1999-2004

RDML Brian Brannman, 2004-2006

RDML Michael H. Mittelman, 2006-2009

RDML Eleanor V. Valentin, 2009-2012

RDML Terry J. Moulton, 2012-2015

RDML Anne M. Swap, 2015-2019

RDML Timothy H. Weber, 2019-2022

RDML Matthew Case 2022-Present



# IN MEMORIAM

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## RDML Robert Hufstader, MC, USN



*The Medical Officer of the Marine Corps (TMO),  
2001-2004*

It is with deep regret I inform you of the passing of Rear Admiral (lower half) Robert Duane “Bob” Hufstader, Jr., Senior Health Care Executive, U.S. Navy (Retired) on 1 June 2022 at age 77. RDML Hufstader enlisted in the U.S. Navy in 1962, serving as a Hospital Corpsman before being commissioned in 1971, then serving a doctor and Senior Health Care Executive until his retirement in 2006 as Command Surgeon for U.S. Pacific Command. His commands included Naval Hospital Keflavik and Naval Hospital Pensacola, and he also served as Deputy Director, Medical Corps and as Senior Medical Officer for the U.S. Marine Corps.

Bob Hufstader enlisted in the U.S. Navy in 1962, serving in San Diego and Japan during the early years of the Vietnam War, advancing to Hospital Corpsman Second Class. He then attended University of California Irvine,

graduating cum laude in 1970 with a Bachelor of Science in Biological Sciences. In June 1970, he entered the University of California San Francisco Medical School. He was commissioned an ensign on 29 November 1971 and promoted to lieutenant (junior grade) in November 1973. He earned his Medical Doctor degree in 1974 from UC San Francisco Medical School and was promoted to lieutenant in June 1974.

In June 1974, Lieutenant Hufstader commenced his internship at Naval Regional Medical Center, San Diego. In July 1975, he reported to the guided-missile cruiser USS CHICAGO (CG-11) as Medical Officer, deploying to the Western Pacific and dodging three typhoons. In October 1976, LT Hufstader was assigned to Naval Regional Medical Center Jacksonville, FL for residency in the Family Practice Department. He was promoted to lieutenant commander in April 1978.

In December 1978, Lieutenant Commander Hufstader was assigned to Naval Hospital Annapolis, MD as a Family Practice Physician. In December 1979, he then reported to Naval Regional Medical Center Memphis, TN as Chief of Family Practice Service. In March 1982, LCDR Hufstader reported to the Defense Language Institute Monterey followed in May 1982 by assignment to Commander Naval Forces Korea Detachment Chinhae as Primary Care Medical Officer. He was promoted to commander in April 1984.

In September 1984, Commander Hufstader reported as Senior Medical Officer on battleship USS NEW JERSEY (BB-62,) homeported in Long Beach, CA. In April 1985, CDR Hufstader was assigned as Executive Officer for Naval Hospital Guantanamo Bay, Cuba. In July 1987, he was assigned to the Office of the Chief of Naval Operations in the Clinical Professional/Healthcare Professional Implementation Group (OP-093.) In August 1987, he reported to Naval Hospital Bethesda, MD in the Medical Practice Group. He was promoted to captain in June 1989.

In July 1989, Captain Hufstader assumed duty as Executive Officer of Naval Hospital Pensacola. In June 1991, CAPT Hufstader assumed command of Naval Hospital Keflavik, Iceland. In July 1994, he reported to the Bureau of Medicine and Surgery in Washington DC as Deputy Chief, Medical Corps. In June 1998, he assumed command of Naval Hospital Pensacola. (At some point he also earned a Master of Medical Management from Tulane University.)

In September 2001, he was designated a rear admiral

(lower half) for duty in a billet commensurate with that rank and assumed duty as Medical Officer to the Marine Corps. He was promoted to rear admiral (lower half) on 1 May 2002. In September 2004, RDML Hufstader assumed duty as Command Surgeon for Commander U.S. Pacific Command in Hawaii. He retired on 1 February 2006.

RDML Hufstader's awards include the Legion of Merit (two awards,) Meritorious Service Medal (two awards,) Navy Commendation Medal, Army Commendation Medal, Navy Achievement Medal, Naval Unit Commendation,

Battle Efficiency Ribbon (two awards,) Good Conduct Medal, National Defense Service Medal (three awards,) Sea Service Ribbon, and Overseas Service Ribbon. I have no information on what RDML Hufstader did after retirement from active duty other than that he enjoyed sailing, reading and spending time with family, especially his grandchildren. Graveside services will be held 1330 on Friday 24 June 2022 in Lane 3, Jacksonville National Cemetery. •

***By Samuel Cox, RADM, Ret., Director of Naval History, Naval History and Heritage Command***

## HMCM (SS) CHARLES "CHARLEY" WILLIAMS



*Force Master Chief of Navy Medicine, 1991-1994*

**H**MCM(SS) Charles "Charley" Williams departed on Eternal Patrol on 18 May 2022, after complications from an aneurysm. Born in Duplin County, NC in 1945, he always loved his home state of North Carolina. For the past few years Charley enjoyed spending his retirement with family between his homes in Denton, TX and Oakdale, CT.

Charley enlisted in the US Navy in 1966. Always

proud of his humble early life, he rose to the highest position in the US Navy Medical Department as Force Master Chief of the Bureau of Medicine and Surgery. He became the first Force to have earned a warfare designation, serving in the submarine force for over 15 years. Some of his favorite tours included being an independent duty corpsman on the USS Cavalla (SSN684), Medical Master Chief and Command Master Chief of SUBLANT, and as Command Master Chief at Naval Hospital Groton. He was also stationed at Great Lakes, Camp Lejeune, and Yokosuka Japan Naval Hospitals. He was awarded the Legion of Merit upon his retirement from active duty in 1994.

After retiring from the military, Charley remained committed to supporting Veterans by serving as the Chief of Staff for the CT Department of Veterans Affairs. As the project manager, he was instrumental in building the new 125-bed CT Veterans Healthcare Center in Rocky Hill. For many years he worked part time on a charter fishing boat out of Groton continuing his lifelong love of being on the water and fishing.

Charley is survived by his loving wife Dianne (Senger); his children Christopher (Chris) Williams of Montville, CT, and Emily Williams Knight (son-in law Alec) of Southlake, TX; grandchildren Elizabeth and Olivia Knight of Southlake, TX, and Sofia Williams of Montville, CT; brother Fred of Charlotte, NC; and numerous loving cousins, nieces, and nephews. He was predeceased by his parents and siblings DeVilla, Wallace, and Clyde.

Charley loved his family, this country, and the mili-

tary (both active duty and veterans). When he was not bragging about his offspring, he could be found watching UCONN women basketball and high school athletics, enjoying great TX BBQ, visiting Captain Scotts in New London, attending church, and always listening to Willie's Roadhouse.

A June Celebration of Life is being held at the

Chesterfield Fire Company in Oakdale, CT on Friday June 3rd from 4-6pm. In the fall, he will be buried at Arlington National Cemetery with full military honors. In lieu of flowers, the family requests that you make a donation in his name to an organization that serves veterans, or personally act to improve the life of a veteran in need. •

## JOSEPH "JOE" EDWARD GOODIN III



*Navy Medical Program Analyst, 1995-2022*

Joseph E. Goodin III, of Stafford VA, passed away suddenly on Thursday, May 12th, 2022. His love for his family (including the four-legged kind) and country, and passion for flying and motorcycles will be sorely missed.

Joe was born in Old Town, ME and grew up in Houlton, ME and Tilton, NH as the oldest of seven children to J Edward Goodin II and Maxine E. Goodin. He joined the U.S. Navy in 1978 and served honorably as a Hospital Corpsman Second Class (HM2) Medical Laboratory Technician for 6 years at the National Naval Medical Center in Bethesda, MD where he met and married his wife, Patricia J. Armstrong. After leaving the Navy, he pursued his degree in Computer Science and entered federal service

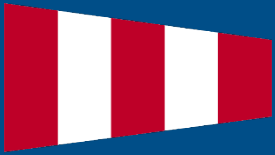
as a Computer Assistant at Naval Hospital Spain in 1988 and progressed through a 34-year distinguished federal career culminating as a Senior Medical Program Analyst for the Office of the Navy Surgeon General, Chief of Naval Operations.

Joe was a committed husband, father and grandfather, carting his three boys to soccer, baseball, and basketball practices and games and even volunteering as assistant coach. He loved on his five granddaughters which was a new experience for him given he raised three boys. His hobbies were computer programing to include creating an alphabet game on a Commodore 64 in the mid-1980s for his sons and assisting in the development and support of an online multi-user dungeon. Additionally he enjoyed scuba diving; reading; trying out new IPAs; motorcycle riding; and flying his Piper Arrow, including to destinations in the Bahamas. For the last several years, he shared his compassion for caring for animals by donating time and money to the local Society for the Prevention of Animal Cruelty (SPCAs) shelters. As a private pilot, and wanting to share his love for flying he also donated his time to volunteer programs such as the Young Eagles. He was a Second Amendment advocate and a responsible gun owner and enthusiast.

Joe is survived by his wife, Patty; his son Ryan, wife Katie and their two daughters Kairi and Elaina; son Kelly, wife Kim, their three daughters Grace, Aria and Phoebe; and son Keeyan. He is also survived by his mother, Maxine; sisters Lori, Peggy, and Julia and their families; brothers George, Greg, John and their families.

Arrangements are being made for a military service at a national cemetery in the future. If desired, donations in his name can be made to the Tunnel to Towers Foundation, 2361 Hylan Blvd, Staten Island, NY 10306; or your local SPCA.” •





# CHARLIE MIKE

## *RENDERING ASSISTANCE*



In an era long before the advent of satellites, cell phones, and radios, seafarers used a communication system based on flags and pennants. Transmitting messages over long distances is called Semaphore, and these visual signals enabled ships to “speak” with other ships at sea.

For more than 30 years, Navy Medicine has used Semaphore Flags part of the International Code of Signals to convey our posture and activity within the Fleet.

In 1987, we adopted the motto “Charlie Golf One” to signify Navy Medicine was “Standing By, Ready to Assist.”

Following the attacks on September 11th, Navy Medicine shifted to “Charlie Papa” meaning that we were “Steaming to Assist” in times of crisis.

In November 2021, we shifted our colors to reflect our active mission of “Rendering Assistance” to our warfighters. We are keeping them in the Fight and ensuring they are operationally ready for that next mission.

In Semaphore, Rendering Assistance is communicated by an Answer Pennant and two Flags -- “Charlie” and “Mike.”

These signal flags will help guide us forward as we continue to deliver operational medical capabilities to our Sailors and Marines.

